1915(i) Home and Community Based Services DRAFT Application
Summary of Public Comments and State Responses

The following Q&A provides the Department's responses to public comments received in response to the draft State Plan Amendment (SPA) released for public comment. Illinois' formal public comment period was held from October 21, 2020 through November 20, 2020.

Questions and comments received were edited and condensed as needed for clarity and to remove duplication. An updated draft of the 1915(i) State Plan Amendment has been posted along with this Q&A.

General

1. **When does the Department intend to release a request for proposals for the HCBS? With respect to the implementation of the SPA, the Department has yet to release an implementation schedule.**

   A. No change made to the application. The Department will provide additional information to stakeholders regarding implementation of the 1915(i) benefit as it becomes available.

2. **The Projected Number of Unduplicated Individuals to Be Served Annually of 10,000 may be inadequate.**

   A. No change made to the application. The estimation of 10,000 youth to be served in year one is only a projection and not an enrollment limit. It is anticipated that the enrollment number will increase in subsequent years.

3. **Component 2: there are concerns that the targeted number served will not meet the need. How will increased need be addressed?**

   A. No change made to the application. HFS is proposing a 2-year phase-in of Component 2 services, as it is anticipated that demand for these services may overwhelm the statewide availability of providers and/or community resources at the time these services launch. To assist with this anticipated demand, HFS will establish training and technical assistance for providers to assist with the service implementation. The services will be available statewide for all eligible customers in Year 4 of the 1915(i) benefit.

4. **While there are comments about client/family choice throughout this plan, how is this being operationalized?**

   A. No change made to the application. HFS has outlined several components of how it will operationalize client/family choice on page 8 of the draft application (Conflict of Interest Standards). Additional operational detail regarding how client/family choice will be assured will be shared as it becomes available.

5. **How will the state "reestablish its statewide PASRR activities?"**

   A. Thank you for your comment. The application has been updated to remove reference to PASRR based upon other comments received.

6. **HFS should consider when the individual participant may not be the primary driver of service planning and delivery and could make reference to "Individuals and/or their caregivers."**

    A. Thank you for your comment. The application has been updated to reference "individuals and/or their caregivers when clinically appropriate" wherever appropriate. It should generally be understood that any reference to "individual," "participant," "enrollee," "member," or other similar term is inclusive of the individual's parent/guardian/caregiver whenever appropriate given the context of the section.

7. **Will the Family Support Program (FSP) be revised/changed with the implementation of 1915i? It appears to be a duplicate program.**

    A. No change made to the application. The Family Support Program is a state funded program that offers community mental health and residential services to eligible children. The 1915(i) is a Medicaid State Plan Amendment that will authorize community-based Medicaid-covered services for Medicaid-eligible children. The Family Support Program will continue as a separate, state funded program.

8. **While the language of current HFS Rules are not necessarily prohibitive for using the DC:0-5 and providers may bill by using the crosswalk with the ICD-10 codes, the current language of the rules do not provide sufficient guidance and recommendation for the use of this developmentally appropriate tool. While, we would hope that IL would require the use of the DC:0-5 in their administrative rule language, we at least would ask HFS to encourage utilization of the DC:0-5 by explicitly stating that it is recommended.**

    A. No changes made to the application. Administrative rule language is outside the scope of the 1915(i) application. However, HFS will take this comment under consideration.

9. **We strongly recommend that the Department alongside other key state agencies prioritize the development and implementation of truly integrated data systems. We strongly implore the Department to make the development of an integrated data system a top priority in the next fiscal year.**

    A. No change made to the application. The development of an integrated data system is outside the scope of the 1915(i) application.

10. **Under the chart's NF (& NF LOC** waivers) column, under the "Supportive Living Program" section, second bullet (pp.19-20), we recommend the language be amended to reads as follows: "No individual participating in the Supportive Living Program (SLP) shall be discriminated against because of race, color, religion belief, political affiliation, sex, orientation, gender identity, gender expression, national origin or disability." We recommend this revision to explicitly protect the LGBTQ+ population from intended or unintended discrimination.**

    A. Thank you for your comment. This section of the application has been streamlined to clarify the Needs-Based Criteria that exists for these other services and programs. However, this comment will be taken under consideration for inclusion in non-discrimination policies.

11. **What types of HFS system changes or upgrades are necessary to add 1915(i) services and enrollees to IMPACT, 834 enrollment files, MEDI, etc.? What is the expected timeline for changes or upgrades?**

A. No change made to the application. This comment is beyond the scope of the 1915(i) application. Information regarding system changes will be shared as it becomes available

12. **Provide robust training and technical assistance to providers through the establishment of resources such as a Medicaid Technical Assistance Center (MTAC), regional Third Party Administrators, or other supports. Many providers with significant experience delivering these new services do not have experience billing Medicaid and/or are not currently certified as a Community Mental Health Center (CMHC) or Behavioral Health Clinic (BHC). The state should provide significant support to providers and should outline its plans in the SPA.**

    A. No change made to the application. Details regarding technical assistance efforts to providers are outside the scope of the 1915(i) application. However, several commenters have requested the Department establish plans to increase support and technical assistance to providers to ensure a successful implementation of the 1915(i) benefit. The Department agrees that technical assistance to providers will be vital to the success of the 1915(i) benefit and other initiatives. The Department will evaluate its options for supporting providers interested in providing 1915(i) services and will share more detailed information as it becomes available.

13. **We ask for the Department to provide updated information on this section in light of the Department's recent release indicating that Integrated Health Homes (IHH) have been delayed indefinitely. It is currently unclear if the Department has a timeline to implement IHH's prior to the 7/1/2022 Supported Employment services implementation date currently outlined in the proposal.**

    A. No change made to the application. The Department intends to implement IHH's prior to **7/1/2022**.

14. **We have concerns regarding multiple case managers and care coordinators-CCSO, YouthCare care coordinator, DCFS/POS case manager who are involved in the lives of youth-in-care. The CCSO might not be the best entity to be the primary provider of care coordination services.**

    A. No change made to application. A key principle of the care coordination provided by the CCSO is to ensure effective communication between all the various parties involved in a child's treatment through the Child and Family Team process. The Department will work with its contractors and sister agencies to clarify roles and responsibilities, as needed.

15. **The IM+CANS is a thorough instrument, but deeply flawed in regard to the provider's ability to adequately assess clients and drive investment in services.**

    A. No change made to the application. The IM+CANS is based upon the Transformational Collaborative Outcomes Measurement (TCOM) philosophy introduced by Dr. John Lyons while ensuring an integrated, comprehensive assessment of an individual's needs (behavioral, physical, and social) and strengths. The strength of the assessment is based upon its ability to create a common language across payer, provider, and customer while ensuring a consumer-centric approach to treatment with the consumer driving vision, goals, and treatment – all through the IM+CANS. Providers experiencing issues in the field of assessment should seek support and input from the University of Illinois School of Social Work or enroll in the UIUC SSW Treatment Planning training here.

Administration and Oversight

16. **This plan appears to increase layers of administration which may decrease access.**

    A. No change made to the application. The plan is designed to increase access to services, while putting customers and families at the center of the assessment and treatment planning process. The Department will be gathering ongoing feedback from customers, families, providers and community stakeholders throughout implementation to ensure that any identified barriers to accessing services are addressed.

17. **Although authority has been delegated to the MCOs and/or a TPA/CCSO for eligibility and utilization management, we hope that HFS takes an active role in ensuring that all eligible individuals are allowed enrollment into the program through a series of adequate checks and balances.**

    A. No change made to the application. HFS will maintain quality and utilization oversight to ensure that eligibility criteria are appropriately applied and that eligible individuals have access to 1915(i) services.

18. **Please explain why the University Partners will be responsible for prior authorization.**

    A. No change made to the application. A University Partner will complete prior authorization reviews only for those individuals eligible for the 1915(i) benefit who are in the fee-for-service system. A University Partner will provide the clinical expertise needed to review service requests for medical necessity. HFS also utilizes University Partners to provide such expertise in other areas of the Illinois Medical Assistance Program.

19. **Please explain who and what is a Third-Party Administrator.**

    A. No change made to the application. A Third-Party Administrator (TPA) is an entity with which HFS contracts for the completion of specific 1915(i) administrative and clinical functions, as noted in Pages 5 – 7 of the Draft 1915(i) application. The TPA for individuals enrolled in an MCO shall be their MCO, while the TPA for individuals in fee-for-service shall be a contracted community organization.

20. **What will be the required timeframe for Therapeutic Support and Individual Support Services to be approved? We are recommending that requests are approved/denied within 2-5 business days.**

    A. No change made to the application. Information regarding timeframes will be shared as it becomes available.

21. **Does a CCSO have to authorize a CMHC/BHC to provide 1915(i) services? If so, what is the process? We are recommending that any authorization process be completed within 5 business days.**

    A. No change made to the application. The Child and Family Team facilitated by the CCSO will develop and authorize the Individual Plan of Care for the child, including services provided by a CMHC/BHC. The child and family will choose their 1915(i) service provider from the HFS 1915(i) Benefit Provider Selection Form, with assistance from the CCSO. Once a provider is selected, the facilitator of the Child and Family Team will be required to connect the child with the provider, and that provider will be included as a member of the Child and Family Team.

Communication and Stakeholder Engagement

22. **What is the overall communication plan for this endeavor? It is recommended that a robust and uniform education plan and access to technical assistance be developed for providers and consumers.**

    A. No change made to the application. The Department is developing a communication plan regarding the 1915(i) benefit. Additional information will be shared as it becomes available.

23. **As the Department develops a process to prevent duplication of services for children in multiple systems, we strongly urge the state to work with providers, families and other stakeholders to ensure that the process works easiest for the family and is efficient in practice.**

    A. No change made to the application. The Department will be gathering ongoing feedback from customers, families, providers and community stakeholders throughout implementation.

24. **We feel it is critical to have a clear and simple process for beneficiaries to provide feedback regarding access and provision of services, access to qualified providers, and issues or thoughts regarding quality of services as outlined in the proposed SPA. We feel it is important the Department serve as the single entity for receiving and responding to beneficiary feedback in order to ensure consistency and equity in the feedback process.**

    A. No change made to the application. The Department agrees that ongoing feedback from customers, providers, and stakeholders related to the 1915(i) benefit is critical for a successful implementation. More information regarding the ongoing avenues and processes for providing feedback to the Department will be shared as details become available.

25. **We recommend that any materials that will be provided to clients/families must be available in all languages for the residents in IL.**

    A. No change made to the application. Thank you for your comment.

26. **The HFS NB Implementation Plan stated there would be "ongoing Class Member and Family Input" into the model development. How did HFS gather this input in the development of the 1915i application?**

    A. No change made to the application. HFS has gathered input related to the services included in the Draft 1915(i) application though the Medicaid Waiver Advisory Committee and the NB Subcommittee of the Medicaid Advisory Committee that has been meeting regularly since July 2018.

27. **What are the communication expectations for communication between HFS, MCOs, CCSOs and CMHC/BHC providers?**

    A. No change made to the application. HFS expects that communication between these entities will be ongoing. HFS is not clear which communication expectations are referenced by the commenter.

28. **Housing Support and Supported Employment are new services to many youth providers. It is good to see an expansion of services. How does HFS plan to engage providers, stakeholders to prepare for implementation of a new service modality?**

    A. No change made to the application. HFS recognizes the need for stakeholder involvement and input throughout the 1915(i) benefit implementation process. More details on these efforts and ongoing opportunities for stakeholder feedback and input will be shared as it becomes available.

Managed Care

29. **There is a concern about the contracts going directly to the managed care companies and IHP's as opposed to the provider agencies rendering the service. With the reimbursement structure including fee-for-service payment arrangements providers end up covering the costs of the unfunded mandates associated with working with the MCOs. There are administrative burdens in areas of prior authorization and on-going utilization management activities that often lead to denying or delaying the client's access to care and providers not receiving full reimbursement.**

    A. No change made to the application. The Department is unclear what contracts the commenter is referring to. The services outlined in the Draft 1915(i) application may be provided by any willing and qualified provider who 1) meets the qualifications for providing the service(s), as outlined in the application; 2) enrolls in the HFS IMPACT system for delivery of the service(s); and 3) for Medicaid Managed Care enrollees, enters into a contract with the individual's MCO.

30. **Per the waiver it appears that HFS intends to contract with Managed Care Organizations to provide many of the services identified in this component.**

    A. No change made to the application. The Draft 1915(i) application does not allow MCOs to deliver any of the 1915(i) services; all 1915(i) services will be rendered by community-based service organizations. The Department does intend to partner with its MCOs in the administration and oversight of the 1915(i) benefit.

31. **Will the MCOs be delegating care coordination to the CCSOs?**

    A. No change made to the application. Care Coordination and Support (CCS) under Component 1 is a medical service, not an administrative function.

32. **What type of data communication is envisioned between the MCO and the CCSO to effectively/securely exchange member information that meets NCQA delegation requirements?**

    A. No change made to the application. This comment is beyond the scope of the 1915(i) application.

33. **When will the MCOs have access to the IM+CANS portal? Will the MCOs be limited to their own members' information?**

    A. No change made to the application. This comment is beyond the scope of the 1915(i) application.

34. **Component 1: suggests that members of the N.B. Consent Decree class be excluded from traditional, MCO-based Complex Care Management programs in order to empower CCSOs in their care coordination efforts and avoid duplication of services. The Department's division of responsibilities should confirm the exclusive role of CCSOs in member-facing care coordination activities and the role of MCOs in support of them.**

    A. No change made to the application. The Department will work with its MCO partners to ensure there is clarity regarding roles and responsibilities amongst various care managers/care coordinators working with customers. HFS strongly believes that MCO Care Managers will continue to play a vital role in supporting the CCSOs and customers receiving Component 1 services through participation in and monitoring of the Child and Family Team process.

35. **Add NCQA Long Term Serve and Supports Distinction to existing contract requirements for Health Plan Accreditation to maximize and strengthen case management/care coordination for MLTSS.**

    A. No change made to the application. This recommendation is outside the scope of the Draft 1915(i) application.

36. **Consider requiring reporting of LTSS measures for plans and CBOs as a tool for quality improvement and incentivizing implementation of strong policies and procedures for care coordination.**

    A. No change made to the application. This recommendation is outside the scope of the Draft 1915(i) application.

37. **How will MCOs support provider billing and reduce billing errors and rejections? Many Illinoisans currently can't access healthcare services because providers don't have the resources to bill MCOs.**

    A. No change made to the application. This comment is outside the scope of the Draft 1915(i) application. However, the Department would like to emphasize the steps taken in recent months/years to streamline administrative overhead wherever possible to reduce burdens to providers. Of note, the Illinois Association of Medicaid Health Plans (IAMHP) has worked with all contracted MCOs to establish a Comprehensive Billing Guide to standardize billing requirements and assist providers working with MCOs. The Department and IAMHP facilitate dedicated billing meetings between different provider types, their representative associations, and the MCOs on a monthly basis to ensure billing issues are being resolved in a timely fashion.

38. **We recommend that the state implement additional measures with its MCOs to ensure that service authorization meets the needs of 1915(i) participants, that utilization review is not improperly limiting services, and that 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that they need services.**

    A. No change made to the application. HFS will maintain quality and utilization oversight to ensure that eligibility criteria are appropriately applied and that eligible individuals have access to 1915(i) services.

Eligibility Criteria

39. **The proposed SPA estimates serving 10,000 youth in the first year. Are any specific populations excluded?**

A. No change made to the application. All Kids and CHIP eligible customers will not be eligible for the 1915(i) benefit but will have access to the same services.

40. **On page 62 there does not appear that any boxes are checked to define any Optional Groups other than the Medically Needy this waiver will serve? Are there optional groups?**

    A. Thank you for your comment. The Department inadvertently missed the checking of boxes in this section. The Groups Covered section of the application has been updated to check the box "No. Does not apply. State does not cover optional categorically needy groups."

41. **What is the required timeframe for HFS to determine whether a client meets eligibility for 1915(i) services? We are recommending that this occur within 2-5 business days.**

    A. No change made to the application. Information regarding timeframes and communication with customers determined eligible for the 1915(i) benefit will be shared as it becomes available.

42. **What is the process of transitioning to different levels of care, i.e., no longer meeting decision support criteria for 1915(i)? We are recommending that there be a transition period with a minimum of 3-6 months to gradually reduce service array.**

    A. No change made to the application. Individuals must continue to meet the Target Group and Needs-Based Eligibility Criteria to receive 1915(i) benefit services. Additional information regarding continuity of care will be shared as it becomes available.

43. **Are the Department of Children and Family Services YouthCare enrollees included? If so, what are the specific care coordination requirements a Care Coordination and Support Organization (CSSO) should be aware of specific to the DCFS population as the community-based child welfare providers have full administrative case management responsibilities and provide child and family team meetings as well?**

    A. No change made to the application. DCFS Youth in Care who meet the Target Group and Needs-Based Eligibility Criteria outlined in the application will be eligible for the 1915(i) benefit. HFS will collaborate with its sister agencies, including DCFS, to coordinate and clarify roles and responsibilities across agencies, as necessary.

44. **We support inclusion in the draft application for the 1915(i) State Plan HCBS of language that makes it clear that individuals with I/DD and Mi diagnoses may be eligible for services.**

    A. No change made to the application. Customers who meet the Target Group and Needs-Based Eligibility Criteria outlined in the application will be eligible for the 1915(i) benefit. Nothing within the proposed Draft 1915(i) application prohibits individuals with dual-system involvement or dual-diagnoses from being determined eligible for the 1915(i) benefit.

45. **Will persons with dual diagnosis (MI/DDD) gain access to 1915 services without involvement in child welfare?**

    A. No change made to the application. Customers who meet the Target Group and Needs-Based Eligibility Criteria outlined in the application will be eligible for the 1915(i) benefit. Involvement with child welfare is not part of the eligibility criteria for the 1915(i) benefit.

46. **Third column placement in ICF DD for children 3-21. Clarity needed. Will 1915i expand ICF DD's for youth ages 3-18? Currently they are only available to qualifying individuals in Illinois ages 18-21.**

    A. No change made to the application. The 1915(i) will not expand ICF/DD services. This section is required within the CMS pre-print, and only outlines the existing eligibility criteria for other Institutional and HCBS Waivers funded by the Illinois Medical Assistance Program.

47. **What are the financial and contractual implications of a client being hospitalized or has an increased level of care? Under Benefit Participation - will participants be able to retain their 1915(i) benefits if they are institutionalized for less than 14 days?**

    A. No change made to the application. Individuals hospitalized for short-term acute care stays will be able to retain their 1915(i) benefit eligibility.

48. **Will youth in residential foster care be excluded from the 1915(i)?**

    A. No change made to the application. The Social Security Act and implementing rules require that the 1915(i) benefit be provided to individuals who reside and receive HCBS in their home or in the community, not in an institution. Consistent with this rule, Youth in Care residing in congregate care settings would not be eligible for services under the 1915(i) benefit until they transition back to a home or community setting and meet eligibility requirements.

49. **When a youth is determined to be eligible for 1915i services, does that automatically opt them into services. What is the opt out process? What are the ramifications if a client/family chose to opt out?**

    A. No change made to the application. A child and their guardian will be notified when they have been determined eligible for the 1915(i) benefit. If a child and family determine that they do not wish to receive the services included in the 1915(i) benefit, they may opt out of those services but still receive other community mental health services for which they are eligible. Additional detail regarding operational processes will be shared as they become available.

50. **It was suggested that this is a consent decree for kids that meet the waiver requirements for children who are physically fragile and that the Department is attempting to get out of facilities. Is this the correct interpretation of the notice Could someone explain what population this amendment applies to?**

    A. No change made to the application. To clarify, the 1915(i) services outlined under Component 1 of the application target children under the age of 21 who have a diagnosed Severe Emotional Disturbance (SED) or Serious Mental Illness (SMI) and who have demonstrated a level of functional impairment that indicates intensive behavioral health services are needed to ameliorate the child's condition.

51. **We recommend adding "complex trauma" as a mental health condition for children under age 21 enrolled in Illinois' Medicaid program to enable a child who has experienced such trauma to be eligible for 1915(i) and other Medicaid services. Many children who will demonstrate symptoms of complex trauma do not directly map to a disorder in the DSM or the ICD, including Post Traumatic Stress Disorder.**

A. No change made to the application. Thank you for your comment. Adjustment to trauma is one of the criteria utilized to determine if a customer meets the Target Group and Needs-Based Eligibility Criteria

52. **We recommend that the decision support criteria that will be developed by HFS and its consultants be shared with the provider community.**

    A. No change made to the application. More information about the eligibility process will be provided as it becomes available.

53. **Has the decision support tool been tested across all ethnic groups?**

    A. No change made to the application. HFS intends to analyze the outputs of the decision support criteria on a regular basis to determine if any adjustments need to be made to address any apparent racial, ethnic or other demographic based disparities.

54. **Will only numeric data points be used in the algorithm to determine eligibility? How will narrative fields be incorporated in eligibility determination?**

    A. No change made to the application. The individual CANS items are being used to establish the needs-based eligibility for Component 1 of the 1915(i) benefit. The CANS instrument includes a rating on each item representing a required action level for each of the individual's needs and strengths. The decision support criteria does not rely on a total score or point total to determine whether an individual meets eligibility for 1915(i) services, but instead focuses on the overall combination of needs, level of impairment, and complexity demonstrated by the individual across multiple domains. Narrative fields will not be used in the initial eligibility determination but may be utilized to complete an appeal or other clinical review.

55. **Since the NB class is defined as "All Medicaid-eligible children under the age of 21 in the State of Illinois: (1) who have been diagnosed with a mental health or behavioral disorder; and (2) for whom a licensed practitioner of the healing arts has recommended intensive home- and community-based services to correct or ameliorate their disorders." will any of the services detailed in the Medicaid Waiver be available to all of the class defined children?**

    A. No change made to the application. To clarify, the 1915(i) is a home and community-based services Medicaid State Plan Amendment, not a Medicaid Waiver. The Department has aligned the operational definition of the N.B. Class, as outlined in the N.B. Consent Decree Implementation Plan, with the Target Group and Needs-Based HCBS Eligibility Criteria of the 1915(i) for Component 1. Children eligible for Component 1 of the 1915(i) will be eligible to receive any of the Component 1 services that are determined to be medically necessary.

56. **Will all Medicaid Children with a mental health or behavioral disorder be allowed to receive any of the waiver services without being qualified for the Care Coordination and Support?**

    A. No change made to the application. Medicaid eligible individuals who meet the Target Group and Needs-Based HCBS Eligibility Criteria outlined in the Draft 1915(i) application are eligible to receive 1915(i) services that are determined to be medically necessary.

57. **Eligibility criteria for children discusses a special focus on psychosis, which is rare in youth. We recommend there be a special focus on trauma which is the common factor amongst the vast majority of those we serve.**

A. Thank you for your comment. The application has been updated to reflect the commenter's recommendation.

58. **Has any consideration beengiven to going through the 21st year to line up with education requirements, through 26 to line up with insurance and/or developmental milestones? Why isn't the age range consistent with the Crisis Act and FSP age of 26 years?**

    A. No change made to the application. The Department has aligned the age range for Component 1 services with the Early Periodic Screening Diagnosis and Treatment (EPSDT) requirement of Medicaid.

59. **We are recommending that clients be notified of their eligibility by the providers who completed the IM+CANs. This will allow for less confusion for client/families and provide personal interface with someone who they just shared personal information.**

    A. No change made to the application. More information about the eligibility and notification process will be provided as it becomes available.

60. **CCS wraparound: Does this mean that youth qualify for High Fidelity Wraparound services only if they are eligible to receive mental health services? If so will this exclude youth with developmental disabilities not served by mental health providers from receiving high fidelity Wraparound?**

    A. No change made to the application. Customers who meet the Target Group and Needs-Based Eligibility Criteria outlined in the application will be eligible for the 1915(i) benefit. Nothing within the proposed Draft 1915(i) application prohibits individuals with dual-system involvement or dual-diagnoses from being determined eligible for the 1915(i) benefit.

61. **HFS in partnership with IL Housing Development Authority and other housing funders should align the eligibility criteria for the Housing Supports service with upcoming housing related projects.**

    A. No change made to the application. Additional stakeholder input will be gathered prior to the implementation of Housing Supports.

62. **I believe there's a transposed CFR site in the 1915i waiver related to the Housing Supports section on page 14. (Those at risk of homelessness upon release from settings defined in 24 CFR 578.31).**

    A. Thank you for your comment. The application has been updated to specify the needs-based eligibility criteria for the Housing Supports service. The criteria "be at risk of homelessness upon release from the settings defined in 24 CFR 578.31" has been replaced with "Be at risk of homelessness upon release from settings such as a healthcare facility, residential treatment setting, correctional program, or similar publicly funded congregate setting."

63. **We recommend that a targeted subset of pregnant/postpartum families with young children identified as experiencing homelessness be able to access this service.**

    A. No change made to the application. The Department is not considering revisions to the Target Group and Needs-based Eligibility Criteria at this time.

64. **We urge the Department to broaden the 1915(i) tenancy support services as much as possible to address health disparities, particularly for Black individuals and other individuals of color, to**

prevent homelessness and disability due to declining mental health, the use of substances and other chronic health conditions. We therefore recommend that the eligibility criteria should include individuals meeting one of the following: a. A diagnosed serious mental health condition or substance use disorder; b. Two or more chronic medical conditions; c. Individuals at risk of institutional placement; or d. Individuals who are homeless or at risk of homelessness (regardless of a diagnosis), using the U.S. Department of Health and Human Services definition of homelessness.

A. No change made to the application. The Department is not considering revisions to the Target Group and Needs-based Eligibility Criteria at this time.

65. **Recommendation to include in the SPA individuals who have previously experienced homelessness and are now housed in homeless-specific housing programs and need ongoing tenancy supports to maintain housing stability.**

A. No change made to the application. The Department is not considering revisions to the Target Group and Needs-based Eligibility Criteria at this time.

66. **We strongly recommend that tenancy supports begin 90 days prior to release from a correctional facility, nursing home, IMD or similar institutional setting to enable identification of housing prior to release to avoid immediate homelessness upon transition.**

A. Thank you for your comment. The application has been updated to allow eligible individuals to receive Care Coordination and Support Services and Housing Support Services up to 60 days prior to discharge from an institutional setting to a home and community-based setting.

67. **We also suggest that HFS consider changing all references to "individual" to "individual and/or caregiver" in order to be more clear when referencing a child. In the instance that a child is the individual participant and at risk of homelessness, it would be the child's caregiver who would need the assistance in securing housing.**

A. No change was made to the application. The service of Housing Supports is targeted at individuals age 17 and older. The Department is not considering expanding the Housing Support service to individuals younger than age 17.

68. **We are concerned that address verification will exclude or become burdensome for children and families who are already experiencing homelessness or have been waitlisted for housing while the beneficiaries are assisted through the housing support services. As it stands, the proposed 1915 (i) SPA does not provide clear guidance or indicate appropriate pathways to ensure that children and families experiencing homelessness, and/ or housing insecurity are able to access these supports as long as they are otherwise eligible.**

A. Thank you for your comment. The section on Home and Community-Based Settings within the application has been updated to add clarifying language consistent with the commenter's recommendations. Guidance to TPAs and CCSOs regarding address verification, including specific processes for individuals and families experiencing homelessness, will be provided in operational documents.

69. **Risk factors for supported employment: Consider adding: 1. Recent loss of a job,2. Recent psychiatric hospitalization.**

A. Thank you for your comment. The application has been updated to take psychiatric hospitalization into account. The Department believes other identified risk factors are adequate to ensure that customers who are at risk of losing a job or have recently lost a job due to a mental health or substance use impairment are able to access Supported Employment services.

70. **The admission criteria for supported employment requires the client to either be at risk of nursing facility placement (institutionalization for I/DD clients) or have significant impairment in ADL plus two co-occurring disorders. The housing support requires homelessness or risk of homelessness, significant functional impairment imminent risk of institutional care. It is recommended that clients receive these services at the onset of their treatment when they can be most effective in helping them achieve stability and enhance the recovery process.**

A. No change made to the application. To receive Supported Employment services, the individual must be 14 years of age or older and be identified as having one or more of the identified risk factors listed under the section "Needs-Based Eligibility Criteria" of the application. These risk factors are not limited to being at risk of nursing facility placement or having significant impairment in ADLs. The Department is targeting Component 2 services to the individuals with greatest demonstrated need for housing and employment supports.

Provider Qualifications / Access to Care

71. **Incorporate expectations for NCQA Patient-Centered Medical Home (PCMH) Recognition with Behavioral Health Distinction as part of the redesign to utilize a value-based strategy that includes integration of behavioral health and social determinants.**

A. No change made to the application. This comment is outside of the current scope of the Draft 1915(i) application.

72. **HFS should consider how very young children (ages 0-5) will be served under this waiver and should consider how this waiver could eventually be used and designed to reach this population. We are concerned that there will not be enough access to qualified providers trained to work with very young children experiencing significant mental and/or behavioral health disorders.**

A. No change made to the application. Customers who meet the Target Group and Needs-Based Eligibility Criteria outlined in the application will be eligible for the 1915(i) benefit. Nothing within the proposed Draft 1915(i) application prohibits very young children from being eligible.

73. **Local non-entities – it is stated on page 6 that "IL will use a combination of enrolled providers and community-based organizations, determined by HFS to be willing and qualified to offer 1915i, as local non-entities"- how is this determination made?**

A. No change made to the application. Provider qualifications are outlined by service in the Draft 1915(i) application. Providers will be determined qualified to provide these services based on the listed qualifications.

74. **Will 1915(i) direct service providers be expected to accept all referrals? What if a client/family wants or needs a 1915(i) service but none are available or able to serve the family locally?**

A. No change made to the application. A CCSO may not decline to serve a child who is eligible for Component 1. Providers of additional 1915(i) services may decline to serve an individual. The Department will monitor network adequacy in partnership with its MCOs as part of the 1915(i) implementation and will work to address any identified service gaps.

75. **It is unclear as to whether there is an expectation that the CCSO that was established for Component 1 is also expected to provide Component 2 services. What is the expectation?**

    A. No change made to the application. There is no expectation that enrolled CCSOs also provide Component 2 services. If a CCSO is the only provider of 1915(i) services within a specified geographic region may provide both Component 1 and Component 2 services, if appropriate Conflict of Interest requirements are established.

76. **Does the Department feel a seven-month implementation timeline is adequate to accomplish its goal of a July 1, 2021 effective date?**

    A. No change made to the application. The Department is pursuing a 7/1/2021 effective date for the 1915(i) services with the recognition that service implementation will be scaled up after the effective date.

77. **We remain concerned with the potential lack of choice afforded to families in geographic regions of the state that have significantly limited networks, and potentially no meaningful access to children's behavioral and mental health specialists. We ask the Department to publicly provide further details on ensuring network adequacy across all geographic regions of the state and identify plans for addressing areas that lack access to qualified providers.**

    A. No change made to the application. Ensuring statewide access to qualified providers for eligible customers is a fundamental requirement of Medicaid. The Department will monitor network adequacy in partnership with its MCOs as part of the 1915(i) implementation and will work with local and other providers to fill any identified gaps. Any pertinent details or information will be shared as it becomes available.

78. **We are concerned that requiring additional training for CMH-HCBS providers, who are likely already limited in rural areas, will result in even fewer qualified professionals deemed qualified for face-to-face assessments.**

    A. No change made to the application. The Department will be providing training using a variety of modalities for 1915(i) services through HFS' existing University Partner at no cost to providers to reduce barriers to service delivery. Having a qualified workforce appropriately trained to provide 1915(i) services is necessary for services to be effective and to achieve positive outcomes for customers.

79. **We suggest that the application make clear that individuals who are not able to obtain an MI diagnosis from a primary care provider and cannot locate or obtain a timely diagnosis from a provider psychiatrist be allowed to obtain an MI diagnosis through a community Mental Health Center (CMHC). In addition, we suggest that diagnostic evaluations arranged by a Local Education Agency (LEA), an Independent Service Coordination (ISC) agency serving the child's region, or a psychiatrist working in a Federally Qualified Health Center be accepted.**

A. No change made to the application. There is nothing within the Draft 1915(i) application or within the Illinois Medical Assistance Program's current behavioral health service delivery that requires an individual obtain a diagnosis specifically from a physician or a psychiatrist to access behavioral health services.

80. **We are equally concerned with how children will be able to access appropriate psychiatric evaluations on a timely basis so that they may be eligible to participate in these new waiver-based treatment services. We suggest that the 1915(i) application make clear that individuals in need of assistance for travel, language interpretation, AT and or augmentative communication may access these services in their effort to gain a psychiatric evaluation in order to access services.**

A. No change made to the application. Psychiatric evaluations are not required for a child to be determined eligible for 1915(i) services. However, the commenter's concerns regarding access to care are noted. The accommodations and services the commenter has identified are part of the broader Illinois Medical Assistance Program, including transportation to and from covered medically necessary services and are therefore outside the scope of the Draft 1915(i) application.

81. **How/when/where will the required trainings occur? There is no detail regarding the level of time and resources that would be required to comply with them. What is the expected number of hours of training? How will agencies be compensated for staff training time as well as the ongoing requirements to fidelity to the EBP? High Fidelity Wrap is intensive, and staff and managers need to be certified. There appears to be other trainings as well: CCS, CASPR, CFT, CPR, Family Peer trainings, Practice Wise or other EBPs.**

A. No change made to the application. Training for the listed services, other than CPR, will be coordinated and provided through the University of Illinois at Urbana-Champaign's Provider Assistance and Training Hub (PATH). PATH is currently providing training on the IM+CANS and Mobile Crisis Response. Their training resources are being augmented to include curriculum and trainers for the other services mentioned. More information will be provided regarding the training schedule as that information becomes available. CPR training is widely available and should be accessed in providers' local communities.

82. **We recommend that all trainings be virtual.**

A. No change made to the application. HFS will be providing training, as required, for 1915(i) services through HFS' existing University Partner at no cost to providers. HFS is committed to training that is efficient and available at times and locations that are convenient for providers, including virtual formats. Details will be published as they become available.

83. **Is it a requirement for CMHC/BHC to be able to provide all the 1915(i) services?**

A. No change made to the application. A CMHC/BHC that is qualified and enrolled to provide 1915(i) services may choose which services they wish to provide.

84. **What is the process for CMHC/BHCs to provide 1915(i) services? Will IMPACT be used to "certify" CMHC/BHC to provide 1915i services? How will a Managed Care Organization (MCO) know they are able to bill one or the other?**

A. No change made to the application. Any entity that wants to provide Care Coordination and Support services will need to participate in the Request for Application process. All providers of 1915(i) services will have to enroll through IMPACT. More information regarding provider enrollment requirements for the additional 1915(i) services will be provided as it becomes available.

85. **There is a significant shortage of C&A psychiatrists - there are concerns that by dividing who is able to provide services through the conflict-free process, access to psychiatric services will be significantly decreased.**

    A. No change made to the application. The 1915(i) conflict-free standards only apply to providers of 1915(i) services, which are not part of the current service array. Psychiatrists and psychiatric services are part of the existing service array and not eligible providers or services under the 1915(i). Implementation of the 1915(i) will open more access to community mental health services for eligible children and will not impact the availability of psychiatric services.

86. **Staffing availability will be the greatest barrier in reaching the projected number of individuals to be served in each service category. Given the low caseloads for C&A service provision especially, the programs outlined could increase statewide workforce demands by 2000-3000 individuals. Given that labor markets have been stretched to the point of breaking, yet we need to do everything possible to provide these critical services, these 2 recommendations must be kept in mind: 1) Wherever possible, allow individuals to work up to the limits of their credentials (e.g. replacing MHP's with RSA's); and 2) Rates have to increasingly take into account this workforce shortage.**

    A. No change made to application. Thank you for your comment. Workforce development is a statewide concern and ensuring statewide access to qualified providers for eligible customers is a fundamental requirement of Medicaid. The Department will monitor workforce and network adequacy in partnership with its MCOs as part of the 1915(i) implementation and will work with local and other providers to fill any identified gaps. Any pertinent details or information will be shared as it becomes available.

87. **We ask the Department to shorten the proposed 5 year procurement cycle to 3 years, to help ensure that no areas will be at risk of network inadequacy. This is particularly important as providers qualified for CMH-HCBS are uniquely qualified specialists, and therefore are likely to be fewer in numbers than other mental health care providers. We are concerned that procurement in 5 year cycles could result in resource inequities across the state, leaving eligible children without meaningful access to the services they are entitled as set forth in the N.B. Consent Decree.**

    A. No change made to the application. The 5-year RFA cycle for CCSOs allows for stability in the network of CCSO as well as Designated Service Area Mobile Crisis Response providers. However, if at any point time it is identified that additional CCSOs are needed within an identified geographic area to ensure access to CCS services for all eligible customers, the Department will issue a special RFA to identify additional qualified providers.

88. **Recommendation that HFS contract with the smallest possible number of high-quality CCSOs in order to ensure appropriate scale, reduce operational complexity, and streamline oversight. Specifically, we advocate contracting with at most two CCSOs per geographic area.**

A. No change made to the application. The Department intends to allow any willing and qualified provider identified through the RFA process to enroll with the Department as a CCSO and will ensure a sufficient number of CCSOs to serve all eligible customers in each Designated Service Area. Collaboration amongst CCSOs within a geographic region will be an expectation outlined in the RFA application.

89. **When does the Department intend to release a RFA for CCSOs? Will a proposing entity be able to submit to be awarded more than one identified service region under their proposal? Will the RFA outline the metrics on which the CCSO providers will be measured to define success in outcomes once operational?**

    A. No change made to the application. Additional detail regarding the RFA process for identifying interested and qualified providers to enroll as CCSOs will be shared as it becomes available.

90. **Will the Department select CCSOs independently or will the MCOs also participate?**

    A. No change made to the application. The Department and a representative from each of the contracted MCOs will review responses to the CCSO RFA using a standardized process and review criteria.

91. **Are only mental health professionals or child welfare agencies or those contracted with them trained to implement the IMCANS?**

    A. No change made to the application. The service of Integrated Assessment and Treatment Planning (IATP) is a requirement for CMHCs, BHCs, and Independent Practitioners delivering services under 89 Ill. Adm. Code 140.453. To be reimbursed for IATP, staff must attend an HFS-approved training and be certified through the Praed Foundation. HFS has targeted its IM+CANS training to those providers; however, anyone interested in the IM+CANS may attend an HFS-approved training.

92. **The IM-CANS is to be used as the Integrated Assessment and Treatment Plan (IATP); however, there is concern about access to the IM-CANS, as particularly in rural areas of the state, there are not enough practitioners trained in it. There needs to be a comprehensive statewide plan for training, roll-out, and implementation of the IM-CANS.**

    A. No change made to the application. The service of IATP was introduced to the Medicaid service array in August 2018. Statewide training and certification for providers of IATP services has been in place since that time, and additional providers are being training on a regular basis. More information regarding available IM+CANS trainings and resources can be found here.

93. **Are there licensing requirements for Respite providers as is done with DCFS?**

    A. No change made to the application. Respite will be provided by CMHCs or BHCs by appropriately trained staff. No additional DCFS licensing of the provider will be required.

94. **Why is there a requirement for CPR certification?**

    A. No change made to the application. Basic safety training is required for staff who are going to provide Respite services.

95. **Intensive-Home Based Services: this service requires the use of evidence-based practices. While ideal, the use ofEBP's can be expensive for organizations. Recommend that the state sponsors or otherwise provides training in recommended practices for community providers.**

    A. No change made to the application. HFS will be providing training in the use of Practicewise through a University Partner. Providers will not be required to pay for attending Practicewise training.

96. **The proposed 1915(i) SPA leaves out critical information including the Department's proposed method of procuring enough trained Care Coordination and Support staff. We ask the Department to clarify the proposed number of care coordination staff required for both High Fidelity Wraparound (CCSW) and Intensive (CCSI) tiers of care.**

    A. No change made to application. Thank you for your comment. Workforce development is a statewide concern and ensuring statewide access to qualified providers for eligible customers is a fundamental requirement of Medicaid. The Department will monitor workforce and network adequacy in partnership with its MCOs as part of the 1915(i) implementation and will work with local and other providers to fill any identified gaps. Any pertinent details or information will be shared as it becomes available.

97. **What will be the process in determining provider eligibility to provide Component 2 services?**

    A. No change made to the application. Providers of Supported Employment and/or Supported Housing must be certified as either a CMHC or a BHC, meet IMPACT enrollment requirements, and have sufficient staff to provide services to customers who are referred for these services. Additional information regarding IMPACT enrollment requirements will be published as it becomes available.

98. **Many organizations who are best suited to provide housing supports or supported employment are not certified as a Community Mental Health Centers (59 IAC 132) or a Behavioral Health Clinics (89 IAC 140.499). The state must provide significant support to assist organizations in becoming certified or should certify organizations with other credentials such as long-standing knowledge and experience.**

    A. No change made to the application. Under the 1915(i), Supported Employment and Housing Support services are only reimbursable to providers enrolled with HFS as a CMHC or BHC. HFS will provide technical assistance to other provider types capable of delivering these services who are interested in enrolling to deliver this service to individuals eligible for the 1915(i) benefit. However, existing providers who are funded outside of the 1915(i) may continue providing services outside of the 1915(i).

<u>Evaluation/Re-evaluation</u>

99. **For the initial evaluation process, we would like to make the suggested change to process point 4. (pg. 12) and recommend it reads as follows: "HFS will notify the child and their family of the child's eligibility for the 1915(i) benefit no longer than 45 days of being determined eligible. This notification will include the child's and family's options of CCSO providers for the initiation of 1915(i) service planning."**

A. Thank you for your comment. The Department has adopted this recommendation. The application has been updated to reflect this change.

100. **We have concerns regarding parity in access to qualified Community-based Behavioral Health (CBH) providers to administer the initial independent evaluation. We ask that the Department clarify the process for potentially eligible children (as identified by HFS), to obtain a qualifying initial evaluation when they are limited by geography, or other barriers to access.**

A. No change made to the application. All Medicaid eligible child seeking community based behavioral health services already receive an IATP from their local CMHC, BHC, or an Independent Practitioner, as defined in 89 Ill. Adm. Code 140.453. The IATP is also the independent evaluation required to determine eligibility for the 1915(i). Any child and family experiencing barriers in accessing an IATP should contact their MCO or the HFS Benefits Hotline for assistance.

101. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. Component 1 and 2 Requirements (p.27): We ask the Department to consider the allowance of telehealth service delivery to alleviate some of the burden in accessing qualified providers for initial and annual assessments, particularly in geographic regions of the state with limited access to qualified health care providers. This may be especially important as we live through the continued uncertainty caused by COVID-19 and future pandemics that could severely limit ability to travel and safely obtain in-person health services.**

A. No change made to the application. The Department's understanding is that a face-to-face assessment is a federal requirement for individuals seeking or receiving 1915(i) services. The Department will work with federal CMS to seek any flexibility determined necessary and allowable to ensure that appropriate safety precautions are being taken during the COVID-19 public health emergency.

102. **The process for reevaluation through the CFT process is confusing. CMHC/BHC providers may be providing Rule 140 and 1915(i) services as authorized by an IM+CANS which is used to determine eligibility for 1915(i) services. In order to have single IM+CANS and with CCSOs responsible for completion/entry in IM+CANS portal, there are concerns that, if timeframes are not met, there will be billing/auditing impact for 1915i providers.**

A. No change made to the application. Once a child is enrolled with the CCSO, the IM+CANS will be updated through the Child and Family Team process. The CFT will include all service providers and other informal supports to ensure that their perspectives are included in the planning process. Services will be authorized by the Individual Plan of Care that is completed by the Child and Family Team, unless additional prior authorization is required by HFS or the child's MCO.

103. **Will the CCSO's completion of the IATP at 6 months and then at 6-month intervals remove the treatment provider's requirement for completion of the IATP? If not, the duplication would seem unnecessary.**

A. No change made to the application. There will be only one active IM+CANS for the child that the CCSO will be responsible for updating through the CFT process. Providers will have access to that IM+CANS to direct their treatment but will not be independently updating it.

104. **To prevent confusion caused by too many individuals doing similar assessments, the behavioral health provider should perform the child's mental health assessment and re-evaluation.**

A. No change made to the application. The CCSO will serve as the lead provider responsible for ensuring a child's IATP is reviewed and updated through the CFT process. It is an expectation that the child, family, service providers, and informal supports collaborate in the review and update of the IATP to ensure all perspectives are represented. Whereas a behavioral health provider may only have insight into the child's behavioral health treatment, the CFT will represent a comprehensive, collaborative view of the child and family's holistic needs and strengths. The CCSO will be in the best position, through the CFT process, to update and maintain a child's IATP.

105. **The IM-CANS should be required no more frequently than annually. Performing such a lengthy assessment every six months overly assesses a child and is unnecessary. We recommend doing the IM-CANS annually, and doing a shorter, far more streamlined re-assessment at six months to guide changes in the child's care plan.**

A. No change made to the application. The Department considers a child's IM+CANS to be a living document, meaning a document that is to be used in the course of treatment to help communicate with children, families, and other important persons in the child's life about treatment and progress. The IM+CANS should be updated by the CFT anytime a significant change occurs in the child's presentation, symptomology, or treatment plan. The re-assessment process should be utilized as an opportunity to check-in with the child and family and make adjustments to treatment as deemed necessary to meet the child and family's treatment goals. Providers experiencing issues with re-assessment should obtain support and input from the University of Illinois School of Social Work.

106. **To enable the immediate start of 1915(i) services for children with significant behavioral health needs, allow the services to begin immediately upon completion of the IM-CANS, and allow providers 45 days to file all the documentation required with the Department.**

A. No change made to the application. The Department retains the sole right to determine eligibility for Component 1 through the application of the decision support criteria.

107. **Component 2: Person-Centered Planning is essential but we urge the state to avoid unnecessary duplication of assessments. Unstably housed participants will likely have completed an assessment for Medicaid Rule 140 services and a coordinated entry system assessment prior to seeking 1915(i) services. Information obtained through these other assessments should be incorporated into the assessment needed under this SPA.**

A. Thank you for your comment. The Evaluation/Re-Evaluation section of the application for Component 2 has been updated to add language regarding the utilization of existing assessment information as part of the assessment and re-assessment process. The Department's operational guidance for TPAs conducting assessments will provide additional information on this process to ensure unnecessary duplication of efforts is avoided whenever possible.

108. **Developing/procuring a statewide screening process that goes beyond the Preadmission Screening and Resident Review (PASRR) referenced in the SPA. PASRR is a tool used by nursing homes and institutional placements. If this benefit is designed to serve a broader population, and we believe it should, the state will need a different screening tool. We recommend integrating**

screening done by local Continua of Care coordinated entry systems into the 1915(i) screening process.

A. Thank you for your comment. The application has been updated to remove references to the PASRR redesign to ensure that screening for Housing Supports is not limited to individuals seeking an institutional level of care.

Services

109. **We would like clarification in the application regarding how an individual's preference for in-person services will be handled during COVID or other public crisis (i.e. will individuals in the home socially distance and wear masks/PPE? Will families be able to obtain PPE under their waiver services to facilitate safe participation? Will this be handled via direct distribution or on a reimbursement basis?) In light of the pandemic and the move to home-based services provided virtually, further guidance defining 'home-based' should be developed.**

A. No change made to the application. The Department's guidance to providers and beneficiaries regarding COVID-19 specific accommodations is outside the scope of the Draft 1915(i) application. Please visit the Department's COVID-19 response page for up-to-date information: https://www.illinois.gov/hfs/Pages/coronavirus.aspx.

110. **We recommend HFS consider requesting CMS permit the state of Illinois to attribute spending addressing SDOH (Social Determinants of Health) beyond supported employment and housing support work toward medical benefit spending, rather than toward administrative functions. We recommend HFS consider modeling a program based upon Massachusetts' Community Support Program for People Experiencing Chronic Homelessness.**

A. No change made to the application. This comment is outside of the scope of the Draft 1915(i) application.

111. **The therapeutic services array listed on the preliminary draft application, page 41, should include Applied Behavior Analysis (ABA) for dually-diagnosed youth. ABA reduces problem behaviors and should be included along with listed therapeutic services.**

A. No change made to the application. ABA services are already covered under the Illinois Medical Assistance Program (https://www.illinois.gov/hfs/MedicalProviders/notices/Pages/prn201030c.aspx).

112. **A service model designed specifically for transition-age youth is outlined in the Early Mental Health and Addictions Treatment Act and has similarities to Community Support Team (CST) services and Assertive Community Treatment (ACT), as well as Coordinated Specialty Care for First Episode Psychosis teams. This multidisciplinary treatment team should be part of the menu of services that transition-age youth and their families could access through the Wraparound process.**

A. No change made to the application. Implementation of the Early Mental Health and Addictions Treatment Act is outside the scope of the Draft 1915(i) application.

113. **We recommend including substance use disorder recovery support services aimed at children under 21 in the 1915(i) services.**

A. No change made to the application. The Department is not considering adding additional services to the Draft 1915(i) application at this time.

114. **It seems that some of these services are just different names for what is already being done: Therapeutic Mentoring is Community Support; CASPR is MCR; Intensive Home- Based Services is in home therapy.**

A. No change made to the application. The services proposed under Component 1 of the 1915(i) application add new flexibility and supports to the behavioral health service delivery system to better support children with high-end behavioral health needs and their families in home and community-based settings. To be clear, CASPR is not a distinct service proposed under the Draft 1915(i) application; rather, it is a component of the broader Care Coordination and Support (CCS) service that purposely aligns with the operational expectations of the existing mobile crisis response system.

Community Support services are rehabilitative, therapeutic services that support the customer's recovery through the use of clinically informed practices such as the development of illness self-management techniques and coping skills. Therapeutic Mentoring services are habilitative services that focus on helping the child develop and practice pro-social behaviors within community settings and serve as an adjunct support to other therapeutic services the child receives.

IHBS uses an evidence-informed approach to clinical services and focuses on enhancing the family's overall functioning and capacity to maintain a child with significant behavioral health challenges in their home and community. Existing Therapy/Counseling services do not require the use of an evidence-informed approach. The emphasis on services provided in the home and the use of Practicewise and other evidence-based practices in the delivery of IHBS makes this service distinct from standard Therapy/Counseling.

115. **Which of the Component 1 services allow staffing with a trained/certified RSA under the supervision of a MHP or licensed clinician? Where do the RSA skill building services fit into the plan?**

A. No change made to the application. The services of Family Peer Support, Respite, and Therapeutic Mentoring can be delivered by staff who meet the qualifications of a Rehabilitative Services Associate (RSA), as defined in 89 Ill. Adm. Code 140.453. Please note that each service has unique staff qualification and training requirements in addition to the staff being qualified as an RSA. The Department is unclear what the commenter means by RSA skill-building services.

116. **Specialized, trauma-based therapies should be included in the behavioral health continuum for children and youth.**

A. No change made to the application. Trauma-based therapies are reimbursable under the existing service of Therapy/Counseling under 89 Ill. Adm. 140.453. Evidence-based practices, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), may also be reimbursed under the 1915(i) service of Intensive Home-Based Services (IHBS) consistent with HFS policy.

117. **The High-Fidelity Wraparound approach to care coordination should take into account the unique developmental changes of transition-age youth and their treatment needs. High-Fidelity**

Wraparound care coordination principles are highly effective for children but are less so with older youth (~ age 16 and older). Wraparound must be flexible enough to allow older youth to take more ownership in treatment decisions, acknowledge the risk-taking behavior of older youth, yet also support them with a strong safety-net to balance their needs.

A. No change made to the application. The Department is developing training for CCSO staff regarding the specific needs of transition age youth, and how these are to be incorporated into the Wraparound process for transition age youth.

118. **All references to 'wraparound' should include the 'high fidelity' language as well. Not to include this adds to confusion about the degree to which the state is committed to an evidence-based implementation of high-fidelity wraparound.**

A. No change made to the application. There are two intensity levels under the Care Coordination and Support (CCS) service: CCS – Intensive (CCSI) and CCS – High Fidelity Wraparound (CCSW). CCSW is based on the evidence-based practice of High-Fidelity Wraparound, while CCSI adheres to the same principles and processes as high-fidelity wraparound, with different requirements for key activities and caseloads. HFS intentionally uses the terminology of "high-fidelity wraparound" when referring specifically to the evidence-based practice and uses the term "Wraparound" when generally referring to underlying principles on which CCS has been designed.

119. **In the IHH model, there were specifics for required members of the team. In this current model, it appears that there is only the requirement for the CCSO to have one MHP per 10 HFW clients or 25 CCI clients as well as a supervisor for a ratio of 1:8 staff - is this correct? Can the MHP also serve non-1915i clients on their caseload?**

A. No change made to the application. CCSOs will need to have care coordinators and supervisors that meet the staffing ratios outlined in the application. Staff who are providing care coordination services under the 1915(i) are expected to be dedicated full time care coordination staff.

120. **Comment is in regards to the Therapeutic Support Services. Could Martial Arts or Self-Defense services be included as an example of intervention? May be helpful for youth who have experienced trauma and need help with behavioral self-control.**

A. No change was made to the application. Martial Arts or Self-Defense services could be considered as wellness activities, allowable under the Individual Support Service.

121. **We request that the Department provide a list of qualifying individual supports and services as it is unclear what services would qualify as no examples are outlined in the current proposed 1915(i) SPA.**

A. Thank you for your comment. The Department is unable to provide a comprehensive list of qualifying activities, services, and supports that can be reimbursed under the Individual Support Service, as this service is meant to be used in a broad, flexible manner that is individualized to meet a child's needs. However, the application has been updated to provide clarity on the types of activities, services, and supports that may be considered under Individual Support Services.

122. **We are concerned that monetary caps on services for Individual Supports and Services (capped at $1500 per state fiscal year) and therapeutic support services (capped at $3000 per state fiscal year) represent exhaustion of a waiver service where a service may otherwise continue under State Medicaid.**

    A. No change made to the application. Individual and Therapeutic Support Services are broad, flexible services that are not otherwise available through the Illinois Medical Assistance Program.

123. **Individual Supports and Services: while we understand the exclusion of basic needs from this category (food, rent, etc.) a family with food or housing instability will likely derive less benefit from interventions until these basic needs are met. Recommend including these basic needs in the allowable costs in this area.**

    A. No change made to the application. Individual Support Services are designed to provide adjunct activities, services, and supports that enhance the therapeutic interventions the child is receiving. CCSOs will be expected to partner with other community resources that help with basic needs.

124. **Will the 1915i eligibility automatically authorize IHBS for the initial 60 days? If not, we are recommending the services be approved/denied within 2-5 business days.**

    A. Thank you for your comment. The application has been updated for clarity. Information regarding operational timeframes will be shared as it becomes available.

125. **For the Intensive Home-Based Services, is it possible for a trained RSA to provide services in place of MHP?**

    A. No change was made to the application. The minimum qualifications for an individual delivering Intensive Home-Based Support Services is a Mental Health Professional (MHP), as defined in 89 Ill. Adm. Code 140.453.

126. **IHBS - two services/week does not make services intensive. Please specify why this would be the direction to take instead of CST? How is this different from the 1115 waiver pilot?**

    A. No change made to the application. Unlike in the 1115 waiver pilot, the Department has not established a minimum amount of services to be delivered each week under Intensive Home-Based Services (IHBS). Although the target population to receive IHBS and Community Support Team (CST) services may be similar, the services themselves are distinct. CST is a team-based service that focuses on increasing an individual's ability to function in the community through the facilitation of illness self-management, skill-building, and the use of natural supports and community resources. IHBS uses an evidence-informed approach to clinical services and focuses on enhancing the family's overall functioning and capacity to maintain a child with significant behavioral health challenges in their home and community. The previous 1115 waiver pilot did not require the use of an evidence-informed clinical approach.

127. **HFS should specify what happens to the respite services if a shelter-in-place order occurs again. While not an ideal way to provide respite, for some youth video would be a welcome way to spend respite time.**

    A. No change made to the application. HFS is not considering allowing respite services virtually.

128. **With the current maximum daily time of 7 hrs., it would be difficult to provide overnight/out of home Respite services. The ability to provide overnight/out of home Respite would allow for essential "cooling off period."**

A. No change made to the application. The Department is not considering adding overnight Respite services at this time.

129. **Training for Family Peer Supports should either use CFPP as required in CST or allow CST to use the new proposed training that will be offered upon implementation of 1915(i) services.**

A. No change made to the application. CFPP credentialed staff will need to complete the training and certification process approved by HFS to be able to provide Family Peer Support under the 1915(i) benefit. The Department will take the recommendation regarding CST under consideration.

130. **Will current CFPP credentialed staff be grandfathered regarding "HFS approved training"? Will current FRD be able to provide services to both 1915(i) eligible parents as wellas SASS and outpatient parents?**

A. No change made to the application. Family Resource Developers and CFPP credentialed staff will need to complete the training and certification process approved by HFS to be able to provide Family Peer Support under the 1915(i) benefit. Family Peer Support services will be available to children eligible for Component 1 of the 1915(i) benefit.

131. **What is the difference between Therapeutic Mentoring and Community Support Individual?**

A. No change made to the application. Community Support services are rehabilitative, therapeutic services that support the customer's recovery through the use of clinically informed practices such as the development of illness self-management techniques and coping skills. Therapeutic Mentoring services are habilitative services that focus on helping the child develop and practice pro-social behaviors within community settings and serve as an adjunct support to other therapeutic services the child receives.

132. **We highly recommend the Department require that all therapeutic mentoring services are at a minimum: developmentally appropriate and strengths based, in accordance with best practices for serving children experiencing behavioral health issues.**

A. No change made to the application. It is the Department's expectation that all behavioral health services be delivered consistent with the values and principles of Systems of Care and Recovery, which would include delivering services in a developmentally appropriate and strengths-based manner. The Department will take into consideration strengthening this expectation in policy.

133. **Who are the required team members for Component 2 for each of the services?**

A. No change made to the application. Supported Employment and Housing Support services may be provided by MHP-level staff employed by a CMHC or BHC and who meet the staff qualifications outlined in the Draft 1915(i) application.

134. **The plan indicates that supported employment is scheduled to start on July 1, 2022 to afford ample time to recruit providers and not overwhelm the system. HFS is reminded that many of the CMHC's are IPS certified and already have quality supportive employment programs in place. The MCO's could harness the strengths of these agencies and offer the services much sooner using the existing network.**

A. No change made to the application. While the Department is appreciative of the existing network of providers potentially ready and willing to deliver Supported Employment services, additional operational structures must be established to administer the Component 2 services in a conflict-free manner as required under the 1915(i). The proposed phase-in of Component 2 allows the Department the time necessary to establish these additional components as well as for the alignment of the Supported Employment and Housing Support services with other initiatives.

135. **Propose reevaluating the enrollment caps for Component 2 services in years two and three of SPA implementation. It is anticipated that these caps do not meet the current need for housing supports. Also recommend that quarterly enrollment levels for Housing Supports and Supported Employment also consider any in race and geographical disparities and adjust accordingly.**

A. No change made to the application. The enrollment targets were established consistent with the annual enrollment limits outlined under the Assistance in Community Integration Services (ACIS) pilot project in the Department's 1115 Behavioral Health Demonstration Waiver.

136. **Housing Supports: the state should explicitly include several other services in order to avoid any confusion between providers and managed care organizations. We recommend specifically authorizing the following: 1. housing navigation to identify affordable housing resources as part of pre-tenancy support; 2. assistance in completing affordable housing recertification process as part of tenancy support; 3. planning and coaching to maintain key relationships with landlords, property management, and neighbors as part of both pre-tenancy and tenancy support; and 4. remote support when needed and requested by the participant via telephone, secure video conferencing, and secure written electronic messaging as part of both pre-tenancy and tenancy support.**

A. No change made to the application. Additional examples and guidance regarding activities that fall within the definition of Housing Supports will be provided in operational policy documents. The Draft 1915(i) application explicitly allows for Housing Supports to be provided in-person, telephonically, or through video communications.

137. **Housing Supports: recommend applying limits in hours of services in a three-month period separately to pre-tenancy and tenancy supports to account for the time intensive process of finding housing and then sustaining residency upon first moving in. Thus, a participant could receive up to 60 hours of pre-tenancy support and 60 hours of tenancy support in a three-month period. These first few months are critical to establishing stable housing and prior authorization should not be required for this level of services when first moving in.**

A. Thank you for your comment. The application has been updated to adopt this recommendation.

138. **Specify that MCOs must approve prior authorization requests for additional hours if at risk for homelessness or institutionalization. Unclear prior authorization processes will cause barriers and put more participants at risk of homelessness and institutional care.**

A. No change made to the application. For Component 2, the Department's contracted MCOs will be allowed to establish their own utilization management protocols and medical necessity criteria, so long as the criteria is supported by generally accepted standards of care. The Department intends to establish a series of workgroups and technical assistance efforts with its MCOs to ensure there is consistency across payers in the understanding of the 1915(i) services.

139. **Regarding housing supports: Has any consideration been given to utilizing the state's share of HUD PRAC 811 dollars to support these housing needs? Given that most funds have been utilized to assist with the Williams and Colbert classes, subsidized residential for those with a mental illness beyond the bounds of those mandated classes has been a significant challenge.**

A. No change made to the application. This comment is outside the scope of the Draft 1915(i) application.

140. **Housing Support Providers: This service could seemingly be provided by a well-trained RSA without requiring an MHP.**

A. Thank you for your comment. The application has been updated to reflect changes to staff qualifications for both Housing Support and Supported Employment.

141. **How will supported employment activities coordinate with those currently required through the school system?**

A. No change made to the application. Providers of 1915(i) services will be expected to coordinate with any other relevant providers or system partners working with the customer as appropriate.

142. **Can you provide information regarding age of 14 yrs. for Supported employments? What are the activities to be done with a child that age who is unable to get a work permit?**

A. No change made to the application. Beginning Supported Employment services at the age of 14 allows eligible youth to begin developing the knowledge and skills needed to successfully obtain and maintain full-time, competitive, and integrated employment in adulthood. Supported Employment activities that may be conducted with transition-aged youth could include, but are not limited to: education about career options, employment planning, assisting with connections to employers and/or mentors in the career the youth is interested in pursuing, and connecting the youth with work, volunteer, or other vocational opportunities that provide the youth with opportunities for skills development.

143. **Given that eligibility begins at age 14, we strongly urge the inclusion of Supported Education under this service to assist with keeping young people in school and to help them invest in a career path rather than a job.**

A. No change made to the application. The Department is not considering expanding the Supported Employment service to include Supported Education activities.

Conflict of Interest

144. **Duplication of administrative services and expense is a major concern given the SPA requires providers applying to provide services as a Children's Mental Health be either a CMHC or a behavioral health clinic. It is our understanding that a provider applying to be a CMH-HCBS care coordination and support organization cannot also provide services for the clients assigned to them as the CCSO. This means they will have to bid for a region award that is not within their service area or community.**

A. No change made to the application. Please refer to page 8 of the Draft 1915(i) application - Conflict of Interest Standards. It is a federal requirement under the 1915(i) that HCBS services be delivered in a manner that assures the independence of persons performing evaluations, assessments, and plans of care to the extent possible to ensure that services are conflict free. The Department disagrees with the commenter's assessment that providers will have to apply for regions outside of their existing communities/service areas.

145. **Why is the utilization of a separate CCSO a necessary component if the CBHC has established medical necessity and reviews the treatment plan as required through utilization of the IM+CANS? In addition, Section 5 lays out the safeguards in place to ensure that providers in rural areas might perform both the assessment and treatment. It seems that these protections would also be valid in urban areas with more provider entities.**

A. No change made to the application. Ensuring that written conflict of interest standards exist and are enforced is a requirement under the 1915(i). These requirements include an assurance of the independence of persons performing assessments and plans of care. The State may make an exception to these requirements when a provider conducting the independent assessment and plan of care is also the only willing and qualified provider of the 1915(i) services in a geographic area, so long as the state devises conflict of interest protections. However, this "firewall" option is not federal CMS' preferred method for ensuring that HCBS services are delivered to customers in a conflict free manner and is seen as a last resort for those geographic areas where access to providers can be challenging. The Department has designed the roles of the CCSO and providers of other 1915(i) services to best meet the federal conflict of interest requirements.

146. **Does client choice in providers override conflict-free?**

A. No change made to the application. A customer's freedom of choice of providers is a fundamental tenet of the Medical Assistance Program and a core component of ensuring services are delivered in a conflict-free manner. However, consumer choice does not override the conflict of interest requirements established by federal CMS.

147. **Current MCR/SASS providers are often also CMHC providers who have over many years established services and varying levels of care. Having to choose whether to be a CCSO or 1915i provider will have significant impact on provider financial sustainability which will impact/decrease access to services.**

A. No change made to the application. A provider who chooses to become a CCSO will still be able to provide their existing services, including Mobile Crisis Response, to customers who are not enrolled in the 1915(i) benefit. Choosing to provide other 1915(i) services will likewise allow existing providers to offer additional services to customers who are enrolled in the 1915(i).

Either arrangement will allow providers to offer additional services to support financial sustainability and increase access to services.

Crisis Response

148. **Given the network of screening assessment and support service crisis team providers already have in place, is there not a way to incorporate the work of these teams with the CCSO providers while elevating the level of services to meet the crisis assessment, safety and prevention planning and response demands of the SPA? Will the introduction of the CCSO's mean the requirements for SASS crisis response teams will change? If not, the demands of both roles could result in two crisis teams responding to the same crisis.**

A. No change made to the application. Existing Designated Service Area Providers of Mobile Crisis Response, also commonly referred to as SASS or MCR providers, will have the opportunity to apply to become a CCSO. The approved CCSOs will comprise the Department's statewide network of Designated Service Area Providers and will be responsible for ensuring all the responsibilities of that designation are met.

149. **We have concerns regarding the proposed implementation date of July 1, 2020. It is our understanding that the entire children's crisis system will be changing with the introduction of the 1915(i) and that the current MCR/SASS will be subject to RFA; this isn't enough time to adequately build/rebuild systems. Under the proposed timeframe presented during the NB Stakeholder meeting, the RFA will not be released until final stages of JCAR approval which would not be completed until second quarter. There will be time needed for application submission, approval/notification and CCSO agencies' ability to staff for required elements. Trainings will also need to occur prior to implementation. Agencies will have to know their status in order to hire new staff if needed and allocate current staff resources for training.**

A. No change made to the application. The Department appreciates the concern regarding the implementation timeframe. July 1, 2021 will be the proposed effective date of the 1915(i) benefit. However, the Department will ensure that there is adequate time for the RFA process, for training related to the new services and for stakeholder input as the new services are being implemented.

150. **What is the process for accessing CASPR services? Will CARES still be the entry point? If so, how will they be able to identify 1915(i) eligibility when they are currently unable to consistently identify geography/funding in real time?**

A. No change made to the application. The CARES line will remain the single, standardized point of crisis intake for all children requiring publicly-funded crisis response in the state of Illinois. Children receiving Component 1 services under the 1915(i) may also contact their Care Coordinator/CCSO directly to access crisis services.

151. **Since it has been explained that only CCSO agencies will be providing MCR/SASS services, will CCSO's also be responsible for providing adult MCR services?**

A. No change made to the application. CCSOs will be required to respond 24 hours a day, 7 days a week to all mobile crisis referrals from the CARES line on a no-decline basis.

Quality and Reporting

152. **We are concerned that the Department has not included any outcomes-based quality measures for this SPA. It is especially worrisome that this proposed SPA does not include any specific focus on meaningful outcomes, as the proposed measures for the children's IHH (pertaining to the Department's 2016 1115 Behavioral Health Waiver) included explicit measures for assessing outcomes including school readiness.**

A. No change made to the application. The seven quality measures addressed in the 1915(i) application are CMS requirements and must be addressed in the application. Additional outcome measures will be required as part of the implementation of the 1915(i) benefit.

153. **We ask the Department to establish a statewide task force immediately upon approval of the proposed 1915(i) SPA, to identify and develop no fewer than 3 outcomes specific quality measures to be included as required reporting no later than January 1, 2022. Furthermore we ask that the taskforce be reflective of the broad range of systems and stakeholders included in this SPA including but not limited to: representatives of HFS, qualified providers as outlined in this proposed SPA, children's mental and behavioral health advocates, educators, and peer support specialists.**

A. No change made to the application. Thank you for your comment. HFS will take this recommendation under consideration.

154. **We ask that all reporting pertaining to quality improvement be made public in aggregate at least annually unless otherwise indicated in the Quality Improvement Strategies chart (pp. 50- 60). We feel transparency in reporting and data are imperative to the continued improvement of this benefit.**

A. No change made to the application. Thank you for your comment. HFS will take this recommendation under consideration.

155. **What is the time period that all quality assurance and quality improvement activities will be reported? We recommend that the state collect and make public all non-identifying demographic information of clients served in the programs.**

A. No change made to the application. HFS intends to publicly post reports and dashboards that contain aggregate, de-identified data relevant to the 1915(i) benefit. Additional operational information regarding reporting and timeframes will be shared as it becomes available.

156. **Under Remediation and Frequency of Analysis and Aggregation column for 1), a), b), and c) we recommend the language be amended to read as follows: "a), b) and c) If a Corrective Action Plan (CAP) is needed, the CCSO/TPA must submit a CAP within 10 working days to HFS designee or UP. HFS designee or UP will approve the CAP and submit to HFS and MCO, as applicable, within 20 working days. HFS designee or the UP will follow up with the program 90 days after the approval of the CAP. If the CAP has not been implemented (meaning that the program has not come into compliance), HFS designee or UP will report to HFS and MCO who shall apply penalties for ongoing noncompliance. HFS designee or UP will provide an annual report of findings with aggregate statistics for overall program performance and recommendations for additional remediation activities."**

A. No change made to the application. The Department is not able to commit to a potential contractual requirement related to sanctions this early in the planning process for the 1915(i).

Reimbursement

157. **The financial compensation plan eludes is fee for service however the fee schedule rate is expected to be set as of July 1, 2021. Without benefit of the financial information we are unable to gauge sustainability. It is recommended that provider input and data be taken into account when developing rates. Providers and community stakeholders should have an opportunity to provide additional comments after the fee schedule is published.**

A. No change made to the application. HFS will follow normal processes for establishing and notifying the public of the rates for 1915(i) services.

158. **The state provides little detail in how it intends to establish rates for the 1915i SPA. We urge the state to use a transparent rate setting tool to establish appropriate reimbursement based on actual costs. We recommend using a tool such as the CSH Services Budget Tool. It can allow systems and programs calculate total cost of care to agencies based upon evidenced based models.**

A. No change made to the application. HFS will follow normal processes for establishing and notifying the public of the rates for 1915(i) services.

159. **Statewide rate setting is also problematic. Urban areas may have higher costs of living, but often service participants live in areas close to each other or even in the same building. In rural areas, staff often must travel between communities and given that travel is not a billable service for these services, our experience states that rural areas need higher rates to consider the travel between locations.**

A. No change made to the application. HFS will follow normal processes for establishing and notifying the public of the rates for 1915(i) services.

160. **How will 1915i services be billed? Will they be a part of the IM+CANS treatment plan?**

A. No change made to the application. Details on billing codes and processes for the 1915(i) benefit services will be shared as they become available.

161. **When would agencies be funded in order to build a workforce?**

A. No change made to the application. The funding available under the 1915(i) is only for the provision of services to eligible customers.

162. **There should be an established rate for no-show to account for staff travel. This is consistent with recent Family First contracts with DCFS.**

A. No change made to the application. The funding available under the 1915(i) is only for the provision of services to eligible customers.

163. **Once approved, will all Medicaid MCOs contract with CCSOs at the same rate?**

A. No change made to the application. MCO contracting requirements and expectations are outside the scope of the Draft 1915(i) application.

164. **It seems the inability to provide certain services in the same day limits treatment provision.**

A. No change made to the application. These limitations represent the operationalization of the Department's assurance that 1915(i) benefit services will not be provided to an individual at the same time as another service that is the same in nature and scope.

165. **HFS should specify whether the CCSO will be the priority for billing case management. How will providers be compensated for non-revenue generating activities? This could result in a disincentive for participation as providers will be forced to shift their staff's time to other billable activities to make up for lost income, which will reduce the amount of communication and collaboration occurring.**

A. No change made to the application. Case Management services may not be billed when a child is receiving Care Coordination and Support services to ensure there is no duplication of services.

166. **How will the service providers' currently providing targeted case management be able to ensure their clients will continue to be funded? The need for the provision of service provider targeted case management will not cease with the addition of the CCSO services.**

A. No change made to the application. The responsibility for the completion of case management activities should shift to the CCSO provider for individuals receiving Care Coordination and Support services. This establishes a primary point of accountability for enrolled individuals and allows community behavioral health providers to shift their focus to the provision of treatment services.

167. **If the expectation is that the re-evaluation will occur during a CFT meeting, there needs to be a method to allow for compensation for staff time of non-CCSO clinicians.**

A. No change made to the application. Details on billing codes and processes for the 1915(i) benefit services will be shared as they become available.

168. **Will there be an additional rate for CASPR services? Will those be at minimum of current MCR rate?**

A. No change made to the application. HFS will follow normal processes for establishing and notifying the public of the rates for 1915(i) services.

169. **The rate for Respite should support not only the cost of staff providing services but should also include funding for activities.**

A. No change made to the application. HFS will follow normal processes for establishing and notifying the public of the rates for 1915(i) services.

170. **The rate for Intensive Home-based Services should be an hourly rate and account for the increased cost of administrative and supervisory support. In addition, there are increased costs for evidenced-based training and ongoing fidelity to practice which should be factored into the rate calculation.**

A. No change made to the application. HFS will follow normal processes for establishing and notifying the public of the rates for 1915(i) services.

171. **With the additional training required for Therapeutic Mentoring, the rate for this service should be higher than the current rate for Community Support Individual.**

A. No change made to the application. HFS will follow normal processes for establishing and notifying the public of the rates for 1915(i) services.

172. **The rate for Family Peer Support should be at a minimum the rate of Community Support Individual and should account for required training.**

A. No change made to the application. HFS will follow normal processes for establishing and notifying the public of the rates for 1915(i) services.